Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $5,782.28 for date of service 07/11/01.

   b. The request was received on 01/30/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 01/10/02
   b. HCFA(s) 1450
   c. Letter to Compliance and Practice dated 01/11/02
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Responses to the Request for Dispute Resolution dated 04/16/02
   b. Carrier Methodology
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The Commission's case file does not contain a Notice of Medical Dispute, therefore, all information in the file will be reviewed.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 01/10/02 that they bill all payers identically regardless of whether the injury resulted on the job or not. The Requestor supplied a list of percentage reimbursement of all it's cases during the years of 1998 and 1999. This chart indicates that the average of all payers is 80% and and for Texas Workers' Compensation payers it is 84%. A chart that shows the percentage of payment by Texas Workers' Compensation carriers for the year of 2000 has also been submitted. The provider supplied EOB(s) from other insurance

carriers preceding 09/11/00 that were paid at 100%. The provider states, "This sampling of 100% payment for services rendered at…evidences that: Acceptance of fees for services at…as fair and reasonable occurs across the spectrum of insurances." The provider indicates that Ambulatory Surgical Centers (ASC) are not covered by the Medical Fee Guidelines so they must be paid at a fair and reasonable rate.

2. Respondent: The Respondent's representative correspondence dated 04/16/02 states, "(Insurance carrier), through (Insurance carrier), has developed a methodology to reimburse ambulatory surgical centers….(Carrier) has analyzed procedures performed as ASCs and grouped them in accordance with their intensity. (Carrier) has developed eight groups, ranging from level one (lowest intensity) to level eight (highest intensity). The intensity level is based on where the CPT code falls within the HCFA intensity grouper list….To ensure that local economic conditions are taken into account, (Carrier) applied the HCFA wage index factor to the base reimbursement to arrive at a total reimbursement. If a city is not listed on the wage index, (Carrier) utilized the state wage index."

IV. FINDINGS

1. Based on Commission Rule 133.305 (d) (1) (2), the only date of service eligible for review is 07/11/01.

2. The provider billed the carrier $7,294.25 for services rendered on 07/11/01.

3. The carrier reimbursed the provider $1,511.97 for services rendered on date of service 07/11/01.

4. The total amount in dispute for date of service is $5,782.28.

5. The services provided by the provider include such items as O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy services, Radiology services, anesthesia equipment services, EKG/ ECG monitor services, and Recovery Room services.

6. After reviewing all information in the case file, no other EOB(s) or medical audits were noted. The Medical Review Division's decision is rendered based on denial codes submitted to the provider prior to the date of this dispute being filed.

7. The carrier denied the billed charges by denial codes;
"907 – N-Not appropriately documented/Texas required bill identification;
51 – F-Fee Guidelines/Multiple procedures allowance;
705 – M-No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area."

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"

Per the Texas Worker's Compensation Act and Rules §413.011(b):
Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The carrier submitted reimbursement data to explain how it arrived at what it considers fair and reasonable reimbursement and that meets the requirements of Rule 133.304 (i). Even though the entire methodology may not necessarily be concurred with by the Medical Review Division, the requirements of the Rule have been met. The provider submitted EOB(s) from other carriers in an effort to document fair and reasonable reimbursement. The burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable. Recent SOAH decisions have placed minimal value on EOB(s) for documenting fair and reasonable reimbursement. The willingness of some carriers to reimburse at or near 100% of the billed charges does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(d) of the Texas Labor Code. The EOB(s) provide no evidence of amounts paid on behalf of managed care patients of ASC(s) or on behalf of other non-workers' compensation patients with an equivalent standard of living. Therefore, based on the evidence available for review, the provider is not entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 17th day of June, 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

his document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.